AMENDED IN ASSEMBLY JUNE 27, 2012

AMENDED IN SENATE JANUARY 4, 2012

# SENATE BILL No. 920

**Introduced by Senator Hernandez**

February 18, 2011

An act to amend Sections 14166.12, *14169.3,* 14169.5, *14169.7, 14169.7.5, 14169.11,* 14169.16, 14169.17, 14169.18, *14169.31, 14169.33,* 14169.41, and 14169.42 of, *and to add Section 14166.125 to,* the Welfare and Institutions Code, relating to Medi-Cal, *and making an appropriation therefor*.

LEGISLATIVE COUNSEL'S DIGEST

SB 920, as amended, Hernandez. Medi-Cal: hospitals.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions.

Existing law establishes the continuously appropriated Private Hospital Supplemental Fund, *administered by the California Medical Assistance Commission,* which consists of moneys from various sources used to fund the nonfederal share of supplemental payments to private hospitals. Existing law requires that the ~~money~~ *California Medical Assistance Commission be dissolved after June 30, 2012, and requires that, upon dissolution of the commission, all powers, duties, and responsibilities of the commission be transferred to the Director of Health Care Services.*

*This bill would require the Director of Health Care Services to allocate the fund among eligible private hospitals pursuant to a*

*methodology that is developed in consultation with the statewide associations representing children's hospitals and private DSH hospitals and that ensures, to the extent possible, the hospitals are allocated funding at the level of payments received for the 2011–12 fiscal year, taking into consideration applicable eligibility criteria.*

*Existing law requires that the money* annually transferred to this fund from the General Fund be reduced by specified amounts for the 2012–13 and 2013–14 fiscal years, and that the reductions in supplemental payments to private hospitals that result from the reductions in the amounts transferred from the General Fund be allocated equally, as specified.

This bill would make a technical, nonsubstantive change to those provisions.

Existing law, subject to federal approval, imposes a quality assurance fee, as specified, on certain general acute care hospitals for the period of July 1, 2011, through December 31, 2013. Existing law requires that the moneys collected from the quality assurance fee be deposited into the Hospital Quality Assurance Revenue Fund. Existing law, subject to federal approval, requires that the moneys in the fund be available, upon appropriation by the Legislature, only for certain purposes, including, among other things, making supplemental payments for certain services to private hospitals, increased capitation payments to Medi-Cal managed care plans, and increased payments to mental health plans. Existing *law also authorizes designated and nondesignated public hospitals to be paid direct grants in support of health care expenditures funded by the quality assurance fee.*

*Existing law, subject to federal approval of a Medicaid demonstration project, requires the department to authorize local Low Income Health Programs (LIHPs), as defined, to provide scheduled health care services to eligible individuals, which includes the Medicaid Coverage Expansion (MCE) population, as defined. Existing law establishes the Low Income Health Program MCE Out-of-Network Emergency Care Services Fund, which consists of moneys transferred from governmental entities on a voluntary basis and from the Hospital Quality Assurance Revenue Fund in specified amounts, to be used by the department, upon appropriation by the Legislature, to fund the nonfederal share of supplemental payments made to private hospitals and nondesignated public hospitals that are outside the LIHP coverage network for providing emergency and poststabilization services to the MCE population.*

*Existing* law provides that the provisions governing the various payments *and grants* shall become inoperative on September 1, 2013, if the department has not received federal approval or a specified letter that indicates likely federal approval on or before September 1, 2013. Existing law also provides that the provisions governing the various payments *and grants* shall remain in effect only until July 1, 2014, the date of the last payment of quality assurance fee payments, or the date of the last payment of specified payments from the department, whichever is later.

*This bill would modify the calculation of the quality assurance fee and would make changes to the calculation of the supplemental amounts paid to private hospitals for the provision of hospital inpatient services. This bill would also increase the aggregate amount of the grants to nondesignated public hospitals for each fiscal year. This bill would reduce the amount of the proceeds from the quality assurance fee that would be transferred into the Low Income Health Program MCE Out-of-Network Emergency Care Services Fund per subject fiscal year and would delete nondesignated public hospitals as a recipient of moneys from that fund.*

This bill would instead provide that the provisions governing the various payments *and grants* shall become inoperative on December 1, 2013, if the department has not received federal approval or the specified letter indicating likely federal approval. This bill would extend the operative date of the provisions governing the various payments *and grants* to January 1, 2015, and make related changes. This bill would make other technical, nonsubstantive changes to these provisions.

*This bill would appropriate $200,000 from the General Fund to the State Department of Health Care Services for administration.*

Vote: ~~majority~~ *2/3*. Appropriation: ~~no~~ *yes*. Fiscal committee: yes. State-mandated local program: no.

*The people of the State of California do enact as follows:*

SECTION 1. Section 14166.12 of the Welfare and Institutions Code is amended to read:

14166.12. (a) The California Medical Assistance Commission shall negotiate payment amounts, in accordance with the selective provider contracting program established pursuant to Article 2.6 (commencing with Section 14081), from the Private Hospital Supplemental Fund established pursuant to subdivision (b) for

distribution to private hospitals that satisfy the criteria of Section 14085.6, 14085.7, 14085.8, or 14085.9.

(b) The Private Hospital Supplemental Fund is hereby established in the State Treasury. For purposes of this section, "fund" means the Private Hospital Supplemental Fund.

(c) Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to the department for the purposes specified in this section.

(d) Except as otherwise limited by this section, the fund shall consist of all of the following:

(1) One hundred eighteen million four hundred thousand dollars ($118,400,000), which shall be transferred annually from General Fund amounts appropriated in the annual Budget Act for the Medi-Cal program, except as follows:

(A) For the 2008–09 fiscal year, this amount shall be reduced by thirteen million six hundred thousand dollars ($13,600,000) and by an amount equal to one-half of the difference between eighteen million three hundred thousand dollars ($18,300,000) and the amount of any reduction in the additional payments for distressed hospitals calculated pursuant to subparagraph (B) of paragraph (3) of subdivision (b) of Section 14166.20.

(B) For the 2012–13 fiscal year, this amount shall be reduced by seventeen million five hundred thousand dollars ($17,500,000).

(C) For the 2013–14 fiscal year, this amount shall be reduced by eight million seven hundred fifty thousand dollars ($8,750,000).

(2) Any additional moneys appropriated to the fund.

(3) All stabilization funding transferred to the fund pursuant to paragraph (2) of subdivision (a) of Section 14166.14.

(4) Any moneys that any county, other political subdivision of the state, or other governmental entity in the state may elect to transfer to the department for deposit into the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws.

(5) All private moneys donated by private individuals or entities to the department for deposit in the fund as permitted under applicable federal Medicaid laws.

(6) Any interest that accrues on amounts in the fund.

(e) Any public agency transferring moneys to the fund may, for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless

otherwise prohibited by law. A public agency may also utilize its general funds or any other public moneys or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.

(f) The department may accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal financial participation to the full extent permitted by law. With respect to funds transferred or donated from private individuals or entities, the department shall accept only those funds that are certified by the transferring or donating entity that qualify for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable. The department may return any funds transferred or donated in error.

(g) Moneys in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section.

(h) Any funds remaining in the fund at the end of a fiscal year shall be carried forward for use in the following fiscal year.

(i) Moneys shall be allocated from the fund by the department and shall be applied to obtain federal financial participation in accordance with customary Medi-Cal accounting procedures for purposes of payments under this section. Distributions from the fund shall be supplemental to any other Medi-Cal reimbursement received by the hospitals, including amounts that hospitals receive under the selective provider contracting program (Article 2.6 (commencing with Section 14081)), and shall not affect provider rates paid under the selective provider contracting program.

(j) Each private hospital that was a private hospital during the 2002–03 fiscal year, received payments for the 2002–03 fiscal year from any of the prior supplemental funds, and, during the project year, satisfies the criteria in Section 14085.6, 14085.7, 14085.8, or 14085.9 to be eligible to negotiate for distributions under any of those sections, shall receive no less from the Private Hospital Supplemental Fund for the project year than 100 percent of the amount the hospital received from the prior supplemental funds for the 2002–03 fiscal year. Each private hospital described in this subdivision shall be eligible for additional payments from the fund pursuant to subdivision (k).

(k) All amounts that are in the fund for a project year in excess of the amount necessary to make the payments under subdivision (j) shall be available for negotiation by the California Medical Assistance Commission, along with corresponding federal financial participation, for supplemental payments to private hospitals, which for the project year satisfy the criteria under Section 14085.6, 14085.7, 14085.8, or 14085.9 to be eligible to negotiate for distributions under any of those sections, and paid for services rendered during the project year pursuant to the selective provider contracting program established under Article 2.6 (commencing with Section 14081).

(*l*) The amount of any stabilization funding transferred to the fund, or the amount of intergovernmental transfers deposited to the fund pursuant to subdivision (o), together with the associated federal reimbursement, with respect to a particular project year, may, in the discretion of the California Medical Assistance Commission, be paid for services furnished in the same project year regardless of when the stabilization funds or intergovernmental transfer funds, and the associated federal reimbursement, become available, provided the payment is consistent with other applicable federal or state law requirements and does not result in a hospital exceeding any applicable reimbursement limitations.

(m) The department shall pay amounts due to a private hospital from the fund for a project year, with the exception of stabilization funding, in up to four installment payments, unless otherwise provided in the hospital's contract negotiated with the California Medical Assistance Commission, except that hospitals that are not described in subdivision (j) shall not receive the first installment payment. The first payment shall be made as soon as practicable after the issuance of the tentative disproportionate share hospital list for the project year, and in no event later than January 1 of the project year. The second and subsequent payments shall be made after the issuance of the final disproportionate hospital list for the project year, and shall be made only to hospitals that are on the final disproportionate share hospital list for the project year. The second payment shall be made by February 1 of the project year or as soon as practicable after the issuance of the final disproportionate share hospital list for the project year. The third payment, if scheduled, shall be made by April 1 of the project year. The fourth payment, if scheduled, shall be made by June 30 of the

project year. This subdivision does not apply to hospitals that are scheduled to receive payments from the fund because they meet the criteria under Section 14085.7 and do not meet the criteria under Section 14085.6, 14085.8, or 14085.9, which shall be paid in accordance with the applicable contract or contract amendment negotiated by the California Medical Assistance Commission.

(n) The department shall pay stabilization funding transferred to the fund in amounts negotiated by the California Medical Assistance Commission and shall pay the scheduled payments in accordance with the applicable contract or contract amendment.

(o) Payments to private hospitals that are eligible to receive payments pursuant to Section 14085.6, 14085.7, 14085.8, or 14085.9 may be made using funds transferred from governmental entities to the state, at the option of the governmental entity. Any payments funded by intergovernmental transfers shall remain with the private hospital and shall not be transferred back to any unit of government. An amount equal to 25 percent of the amount of any intergovernmental transfer made in the project year that results in a supplemental payment made for the same project year to a project year private DSH hospital designated by the governmental entity that made the intergovernmental transfer shall be deposited in the fund for distribution as determined by the California Medical Assistance Commission. An amount equal to 75 percent shall be deposited in the fund and distributed to the private hospitals designated by the governmental entity.

(p) A private hospital that receives payment pursuant to this section for a particular project year shall not submit a notice for the termination of its participation in the selective provider contracting program established pursuant to Article 2.6 (commencing with Section 14081) until the later of the following dates:

(1) On or after December 31 of the next project year.

(2) The date specified in the hospital's contract, if applicable.

(q) (1) For the 2007–08, 2008–09, and 2009–10 project years, the County of Los Angeles shall make intergovernmental transfers to the state to fund the nonfederal share of increased Medi-Cal payments to those private hospitals that serve the South Los Angeles population formerly served by Los Angeles County Martin Luther King, Jr.-Harbor Hospital. The intergovernmental transfers required under this subdivision shall be funded by county tax

revenues and shall total five million dollars ($5,000,000) per project year, except that, in the event that the director determines that any amount is due to the County of Los Angeles under the demonstration project for services rendered during the portion of a project year during which Los Angeles County Martin Luther King, Jr.-Harbor Hospital was operational, the amount of intergovernmental transfers required under this subdivision shall be reduced by a percentage determined by reducing 100 percent by the percentage reduction in Los Angeles County Martin Luther King, Jr.-Harbor Hospital's baseline, as determined under subdivision (c) of Section 14166.5 for that project year.

(2) Notwithstanding subdivision (o), an amount equal to 100 percent of the county's intergovernmental transfers under this subdivision shall be deposited in the fund and, within 30 days after receipt of the intergovernmental transfer, shall be distributed, together with related federal financial participation, to the private hospitals designated by the county in the amounts designated by the county. The director shall disregard amounts received pursuant to this subdivision in calculating the OBRA 1993 payment limitation, as defined in paragraph (24) of subdivision (a) of Section 14105.98, for purposes of determining the amount of disproportionate share hospital replacement payments due a private hospital under Section 14166.11.

(r) (1) The reductions in supplemental payments under this section that result from the reductions in the amounts transferred from the General Fund to the Private Hospital Supplemental Fund for the 2012–13 and 2013–14 fiscal years under subparagraphs (B) and (C) of paragraph (1) of subdivision (d) shall be allocated equally in the aggregate between children's hospitals eligible for supplemental payments under this section and other hospitals eligible for supplemental payments under this section. When negotiating payment amounts to a hospital under this section for the 2012–13 and 2013–14 fiscal years, the California Medical Assistance Commission, or its successor agency, shall identify both a payment amount that would have been made absent the funding reductions in subparagraphs (B) and (C) of paragraph (1) of subdivision (d) and the payment amount that will be made taking into account the funding reductions under subparagraphs (B) and (C) of paragraph (1) of subdivision (d). For purposes of this

subdivision, "children's hospital" shall have the meaning set forth in paragraph (13) of subdivision (a) of Section 14105.98.

(2) This subdivision shall not preclude the department from including some or all of the reductions under this section within the payments made under a new diagnosis-related group payment methodology for the 2012–13 fiscal year or the 2013–14 fiscal year. In the event the department includes some or all of the amounts, including reductions, within the payments made under a new diagnosis-related group payment methodology for the 2012–13 fiscal year or the 2013–14 fiscal year, the department, in implementing the reductions in paragraph (1) of subdivision (d), shall, to the extent feasible, utilize the allocation specified in paragraph (1).

*SEC. 2. Section 14166.125 is added to the Welfare and Institutions Code, to read:*

*14166.125. The director shall allocate the Private Hospital Supplemental Fund among eligible private hospitals pursuant to a methodology developed in consultation with the statewide associations representing children's hospitals and private DSH hospitals. This methodology shall, to the extent possible, ensure that the hospitals are allocated funding at the level of payments received for the 2011–12 fiscal year, taking into consideration applicable eligibility criteria.*

*SEC. 3. Section 14169.3 of the Welfare and Institutions Code is amended to read:*

14169.3. (a) Except as provided in Section 14169.19, private hospitals shall be paid supplemental amounts for the provision of hospital inpatient services for the program period as set forth in this section. The supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services and shall not affect any other payments to hospitals. The supplemental amounts shall result in payments equal to the statewide aggregate upper payment limit for private hospitals for each subject fiscal year as it may be modified pursuant to Section 14169.19.

(b) Except as set forth in subdivisions (g) and (h), each private hospital shall be paid the following amounts as applicable for the provision of hospital inpatient services for each subject fiscal year:

(1) Nine hundred ~~seventeen dollars and sixty-six cents ($917.66)~~ *seventy-four dollars and ten cents ($974.10)* multiplied by the

hospital's general acute care days for supplemental payments for the 2011–12 subject fiscal year, one thousand ~~eighty-six dollars and seventy-two cents ($1,086.72)~~ *eighty-nine dollars and ninety-two cents ($1,089.92)* multiplied by the hospital's general acute care days for supplemental payments for the 2012–13 subject fiscal year, and one thousand ~~three hundred five dollars and fifty-three cents ($1,305.53)~~ *two hundred sixty-four dollars and six cents ($1,264.06)* multiplied by the hospital's general acute care days for supplemental payments for the 2013–14 subject fiscal year, *divided by two*.

(2) For the hospital's acute psychiatric days that were paid directly by the department and were not the financial responsibility of a mental health plan, six hundred ninety-five dollars ($695) multiplied by the hospital's acute psychiatric days for supplemental payments for the 2011–12 subject fiscal year, seven hundred ninety dollars ($790) multiplied by the hospital's acute psychiatric days for supplemental payments for the 2012–13 subject fiscal year, and nine hundred ~~ninety-five dollars ($995)~~ *fifty-five dollars ($955)* multiplied by the hospital's acute psychiatric days for supplemental payments for the 2013–14 subject fiscal year, *divided by two*.

(3) ~~One~~ *(A) For the 2011–12 and 2012–13 subject fiscal years, one* thousand three hundred fifty dollars ($1,350) multiplied by the number of the hospital's high acuity days if the hospital's Medicaid inpatient utilization rate is less than ~~41.1~~ *41.6* percent and greater than 5 percent and at least 5 percent of the hospital's general acute care days are high acuity days. ~~This~~

*(B) For the 2013–14 subject fiscal year, one thousand three hundred fifty dollars ($1,350) multiplied by the number of the hospital's high acuity days, divided by two, if the hospitals Medicaid inpatient utilization rate is less than 41.6 percent and greater than 5 percent and at least 5 percent of the hospital's general acute care days are high acuity days.*

*(C) The* amount *under this paragraph* shall be in addition to the amounts specified in paragraphs (1) and (2).

(4) ~~One~~ *(A) For the 2011–12 and 2012–13 subject fiscal years, one* thousand three hundred fifty dollars ($1,350) multiplied by the number of the hospital's high acuity days if the hospital qualifies to receive the amount set forth in paragraph (3) and has been designated as a Level I, Level II, Adult/Ped Level I, or Adult/Ped Level II trauma center by the Emergency Medical

Services Authority established pursuant to Section 1797.1 of the Health and Safety Code. ~~This~~

*(B) For the 2013–14 subject fiscal year, one thousand three hundred fifty dollars ($1,350) multiplied by the number of the hospital's high acuity days, divided by two, if the hospital qualifies to receive the amount set forth in paragraph (3) and has been designated as a Level I, Level II, Adult/Ped Level I, or Adult/Ped Level II trauma center by the Emergency Medical Services Authority established pursuant to Section 1797.1 of the Health and Safety Code.*

*(C) The* amount *under this paragraph* shall be in addition to the amounts specified in paragraphs (1), (2), and (3).

(c) A private hospital that provided Medi-Cal subacute services during the 2009 calendar year and has a Medicaid inpatient utilization rate that is greater than 5 percent and less than 41.6 percent shall be paid a supplemental amount during each subject fiscal year equal to 40 percent of the Medi-Cal subacute payments paid by the department to the hospital during the 2009 calendar year, as reflected in the state paid claims file prepared by the department on July 14, 2011, except for the 2013–14 subject fiscal year during which the supplemental amount shall be equal to 20 percent of the Medi-Cal subacute payments paid by the department to the hospital during the 2009 calendar year, as reflected in the state paid claims file prepared by the department on July 14, 2011.

(d) (1) In the event federal financial participation for a subject fiscal year is not available for all of the supplemental amounts payable to private hospitals under subdivision (b) due to the application of a federal upper payment limit or for any other reason, both of the following shall apply:

(A) The total amount payable to private hospitals under subdivision (b) for the subject fiscal year shall be reduced to reflect the amount for which federal financial participation is available.

(B) The amount payable under subdivision (b) to each private hospital for the subject fiscal year shall be equal to the amount computed under subdivision (b) multiplied by the ratio of the total amount for which federal financial participation is available to the total amount computed under subdivision (b).

(2) In the event federal financial participation for a subject fiscal year is not available for all of the supplemental amounts payable to private hospitals under subdivision (c) due to the application of

a federal upper payment limit or for any other reason, both of the following shall apply:

(A) The total amount payable to private hospitals under subdivision (c) for the subject fiscal year shall be reduced to reflect the amount for which federal financial participation is available.

(B) The amount payable under subdivision (c) to each private hospital for the subject fiscal year shall be equal to the amount computed under subdivision (c) multiplied by the ratio of the total amount for which federal financial participation is available to the total amount computed under subdivision (c).

(e) If the amount otherwise payable to a hospital under this section for a subject fiscal year exceeds the amount for which federal financial participation is available for that hospital, the amount due to the hospital for that subject fiscal year shall be reduced to the amount for which federal financial participation is available.

(f) The amounts set forth in this section are inclusive of federal financial participation.

(g) Payments shall not be made under this section to a new hospital.

(h) Payments shall not be made under this section to a converted hospital.

(i) (1) The department shall increase payments to mental health plans for the program period exclusively for the purpose of making payments to private hospitals. The aggregate amount of the increased payments for a subject fiscal quarter shall be the total of the individual hospital acute psychiatric supplemental payment amounts for all hospitals for which federal financial participation is available.

(2) The payments described in paragraph (1) may be made directly by the department to hospitals when federal law does not require that the payments be transmitted to hospitals via mental health plans.

~~SEC. 2.~~

*SEC. 4.* Section 14169.5 of the Welfare and Institutions Code is amended to read:

14169.5. (a) The department shall increase capitation payments to Medi-Cal managed health care plans for each subject fiscal year as set forth in this section.

(b) The increased capitation payments shall be made as part of the monthly capitated payments made by the department to managed health care plans.

(c) The aggregate amount of increased capitation payments to all Medi-Cal managed health care plans for each subject fiscal year shall be the maximum amount for which federal financial participation is available on an aggregate statewide basis for the applicable subject fiscal year as it may be adjusted pursuant to Section 14169.19.

(d) The department shall determine the amount of the increased capitation payments for each managed health care plan. The department shall consider the composition of Medi-Cal enrollees in the plan, the anticipated utilization of hospital services by the plan's Medi-Cal enrollees, and other factors that the department determines are reasonable and appropriate to ensuring access to high-quality hospital services by the plan's enrollees.

(e) The amount of increased capitation payments to each Medi-Cal managed health care plan shall not exceed an amount that results in capitation payments that are certified by the state's actuary as meeting federal requirements, taking into account the requirement that all of the increased capitation payments under this section shall be paid by the Medi-Cal managed health care plans to hospitals for hospital services to Medi-Cal enrollees of the plan.

(f) (1) The increased capitation payments to managed health care plans under this section shall be made to support the availability of hospital services and ensure access to hospital services for Medi-Cal beneficiaries. The increased capitation payments to managed health care plans shall commence no later than the later of December 31, 2011, or within 90 days of the date on which all necessary federal approvals have been received, and shall include, but not be limited to, the sum of the increased payments for all prior months for which payments are due.

(2) (A) To secure the necessary funding for the payment or payments made pursuant to paragraph (1), the department may accumulate funds in the Hospital Quality Assurance Revenue Fund for the purpose of funding managed health care capitation payments under this article regardless of the date on which capitation payments are scheduled to be paid in order to secure the necessary

total funding for managed health care payments by December 31, 2013.

(B) To the extent feasible, the department shall accumulate funds under subparagraph (A) by retaining 10 percent of the total necessary funding from each of the 10 installments of the quality assurance fee received from hospitals under Article 5.229 (commencing with Section 14169.31), provided that the department may adjust the applicable dates and amounts as necessary to accumulate sufficient funding by December 31, 2013.

(g) Payments to managed health care plans that would be paid consistent with actuarial certification and enrollment in the absence of the payments made pursuant to this section, including, but not limited to, payments described in Section 14182.15, shall not be reduced as a consequence of payment under this section.

(h) (1) Each managed health care plan shall expend 100 percent of any increased capitation payments it receives under this section on hospital services.

(2) The department may issue change orders to amend contracts with managed health care plans as needed to adjust monthly capitation payments in order to implement this section.

(3) For entities contracting with the department pursuant to Article 2.91 (commencing with Section 14089), any incremental increase in capitation rates pursuant to this section shall not be subject to negotiation and approval by the California Medical Assistance Commission.

(i) (1) In the event federal financial participation is not available for all of the increased capitation payments determined for a month pursuant to this section for any reason, the increased capitation payments mandated by this section for that month shall be reduced proportionately to the amount for which federal financial participation is available.

(2) The determination under this subdivision for any month in the program period shall be made after accounting for all federal financial participation necessary for full implementation of Section 14182.15 for that month.

(j) It is the intent of the Legislature that payments made available to designated public hospitals under this section shall replace, to the extent feasible, increased revenues that could be available to the hospitals under Section 14168.7 in the absence of this section and assuming other federal funds to the hospitals would not be

reduced as a result of the payments. If this intent cannot be effectuated under this act, it is the intent of the Legislature to enact subsequent legislation to accomplish this purpose through other means.

*SEC. 5. Section 14169.7 of the Welfare and Institutions Code is amended to read:*

14169.7. (a) Designated public hospitals shall be paid direct grants in support of health care expenditures, which shall not constitute Medi-Cal payments, and which shall be funded by the quality assurance fee set forth in Article 5.229 (commencing with Section 14169.31). The aggregate amount of the grants to designated public hospitals shall be fifty million dollars ($50,000,000) for the 2011–12 fiscal year, forty-three million dollars ($43,000,000) for the 2012–13 fiscal year, and twenty-one million five hundred thousand dollars ($21,500,000) for the 2013–14 fiscal year. The director shall allocate the amounts specified in this subdivision among the designated public hospitals pursuant to a methodology developed in consultation with the designated public hospitals.

(b) Nondesignated public hospitals shall be paid direct grants in support of health care expenditures, and shall be funded by the quality assurance fee set forth in Article 5.229 (commencing with Section 14169.31). The aggregate amount of the grants to nondesignated public hospitals for each subject fiscal year shall be ~~ten million dollars ($10,000,000)~~ *eighteen million six hundred thousand dollars ($18,600,000)*, except that for the 2013–14 subject fiscal year, the aggregate amount of the grants shall be ~~five million dollars ($5,000,000)~~ *nine million three hundred thousand dollars ($9,300,000)*. The director shall allocate the amounts specified in this subdivision among the nondesignated public hospitals pursuant to a methodology developed in consultation with the nondesignated public hospitals.

*SEC. 6. Section 14169.7.5 of the Welfare and Institutions Code is amended to read:*

14169.7.5. (a) The Low Income Health Program MCE Out-of-Network Emergency Care Services Fund is hereby established in the State Treasury. The moneys in the fund shall, upon appropriation by the Legislature to the department, be used solely for the purposes specified in this section. Notwithstanding Section 16305.7 of the Government Code, any and all interest and

dividends earned on money in the fund shall be used exclusively for the purposes of this section.

(b) The fund shall consist of the following:

(1) Funds transferred from governmental entities, at the option of the governmental entity, to the state for deposit into the fund in an aggregate amount of twenty million dollars ($20,000,000) per subject fiscal year, except that for the 2013–14 subject fiscal year, the aggregate amount of the transfer shall be ten million dollars ($10,000,000).

(2) Proceeds of the quality assurance fee set forth in Article 5.229 (commencing with Section 14169.31) that, subject to paragraph (1) of subdivision (a) of Section 14169.36, are transferred from the Hospital Quality Assurance Revenue Fund and deposited into the fund in an aggregate amount of ~~seventy-five million dollars ($75,000,000)~~ *sixty-six million four hundred thousand dollars ($66,400,000)* per subject fiscal year, except that for the 2013–14 subject fiscal year, the aggregate amount of the proceeds of the quality assurance fee deposited into the fund shall be ~~thirty-seven million five hundred thousand dollars ($37,500,000)~~ *thirty-three million two hundred thousand dollars ($33,200,000)*.

(c) Any amounts of the quality assurance fee deposited to the fund in excess of the funds required to implement this section shall be returned to the Hospital Quality Assurance Revenue Fund.

(d) Any amounts deposited to the fund as described in paragraph (1) of subdivision (b) that are in excess of the funds required to implement this section shall be returned to the transferring entity.

(e) Consistent with the Special Terms and Conditions for the California's Bridge to Reform Section 1115(a) Medicaid Demonstration (11-W-00193/9), moneys in the fund shall be used with respect to Low Income Health Programs (LIHPs) operating pursuant to Part 3.6 (commencing with Section 15909) as the source for the nonfederal share of expenditures for coverage for the ~~Medi-Cal coverage expansion~~ *Medicaid Coverage Expansion* (MCE) population of medically necessary hospital emergency services for emergency medical conditions and required poststabilization care furnished by private hospitals ~~and nondesignated public hospitals~~ that are outside the LIHP coverage network, subject to the following:

(1) Moneys in the fund shall only be used to fund the nonfederal share of supplemental payments made to private hospital ~~and~~

~~nondesignated public hospital~~ out-of-network emergency care services providers by the LIHP for the MCE population in accordance with this section.

(2) Supplemental payments under this section shall supplement but shall not supplant amounts that would have been paid absent the provisions of this section.

(f) Moneys in the fund shall be allocated with respect to each subject fiscal year as follows:

(1) Within 60 days after the last day of each subject fiscal year, each LIHP shall report utilization data to the department on approved hospital emergency services for emergency medical conditions and required poststabilization care, in accordance with Paragraph 63.f.ii of the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Demonstration (11-W-00193/9), provided to MCE enrollees by out-of-network private hospitals ~~and nondesignated public hospitals~~ during that year. The reported data shall be as specified by the department, and shall include the number of emergency room encounters and the number of inpatient hospital days.

(2) The department shall, in consultation with the hospital community, determine the amount of funding for the nonfederal share of supplemental payments available for each reported emergency room encounter or inpatient day by dividing the total funds available by the total number of inpatient days or emergency visits in accordance with subparagraphs (A) and (B).

(A) Seventy percent of the moneys in the fund shall be allocated for the nonfederal share of supplemental payments to private hospitals ~~and nondesignated public hospitals~~ for approved out-of-network inpatient hospital emergency and poststabilization care, in accordance with Paragraph 63.f.ii of the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Demonstration (11-W-00193/9).

(B) Thirty percent of the available funds shall be allocated for the nonfederal share of supplemental payments to private hospitals ~~and nondesignated public hospitals~~ for approved out-of-network hospital emergency room services (excluding emergency room visits, in accordance with Paragraph 63.f.ii of the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Demonstration (11-W-00193/9), that resulted in an approved out-of-network inpatient hospital stay), provided that for any

emergency room visit that results in a hospital stay for which a supplemental payment is available under subparagraph (A), no supplemental payment shall be available under this subparagraph.

(C) The allocations and total available fund amount shall be adjusted as necessary so as to be consistent with the requirement in paragraph (1) of subdivision (g).

(g) (1) The department shall obtain federal financial participation for moneys in the fund to the full extent permitted by federal law. Moneys shall be allocated from the fund by the department to be matched by federal funds in accordance with the Special Terms and Conditions for the Medicaid Demonstration, or pursuant to other federal approvals or waivers as necessary.

(2) The department shall disburse moneys from the fund to the LIHPs in accordance with the calculations in subdivision (f) within 60 days after completing the calculations. The moneys shall be distributed to the LIHPs solely for purposes of funding the nonfederal portion of the supplemental out-of-network amounts determined for each service in subdivision (f) to out-of-network hospital emergency care services providers.

(3) The LIHPs shall make the supplemental payments described in paragraph (2) within 30 days of receiving the nonfederal share from the department.

(h) It is the intent of the Legislature that for each subject fiscal year, the first twenty million dollars ($20,000,000), or, for subject fiscal year 2013–14, the first ten million dollars ($10,000,000), of the nonfederal share for the emergency hospital services payments are funded with intergovernmental transfers described in paragraph (1) of subdivision (b).

(i) This section shall be implemented only if, and to the extent that, both of the following conditions exist:

(1) All necessary federal approvals have been obtained and federal financial participation is available.

(2) The ability of the department to maximize federal funding is not jeopardized.

(j) In designing and implementing the program for supplemental payments created under this section, the director shall have discretion, after consultation with the hospital community and the LIHPs, to modify timelines and to make modifications to the operational requirements of this section, but only to the extent

necessary to secure federal approval or to ensure successful operation of the program and to effectuate the intent of this section.

(k) Notwithstanding any other provision of this article or Article 5.229 (commencing with Section 14169.31), federal disapproval of the program developed pursuant to the requirements of this section shall not affect the implementation of the remainder of this article or Article 5.229 (commencing with Section 14169.31).

*SEC. 7. Section 14169.11 of the Welfare and Institutions Code is amended to read:*

14169.11. The department shall make disbursements from the Hospital Quality Assurance Revenue Fund consistent with the following:

(a) Fund disbursements shall be made periodically within 15 days of each date on which quality assurance fees are due from hospitals.

(b) The funds shall be disbursed in accordance with the order of priority set forth in subdivision (b) of Section 14169.33, except that funds may be set aside for increased capitation payments to managed care health plans pursuant to subdivision (f) of Section 14169.5.

(c) The funds shall be disbursed in each payment cycle in accordance with the order of priority set forth in subdivision (b) of Section 14169.33 as modified by subdivision (b), and so that the supplemental payments and grants to hospitals, increased capitation payments to managed health care plans, increased payments to mental health plans, direct payments to hospitals of acute psychiatric supplemental payments, and supplemental payments for out-of-network emergency and poststabilization services for the Low Income Health Program are made to the maximum extent for which funds are available.

(d) To the maximum extent possible, consistent with the availability of funds in the quality assurance fund and the timing of federal approvals, the supplemental payments and grants to hospitals, increased capitation payments to managed health care plans, and increased payments to mental health plans under this article shall be made before December 31, 2013, except that supplemental payments for out-of-network emergency and poststabilization services for the Low Income Health Program shall be made before April 1, 2014.

(e) The aggregate amount of funds to be disbursed to private hospitals shall be determined under Sections 14169.2 and 14169.3. The aggregate amount of funds to be disbursed to managed health care plans shall be determined under Section 14169.5. The aggregate amount of direct grants to designated and nondesignated public hospitals shall be determined under Section 14169.7. The aggregate amount of supplemental payments to be disbursed to private hospitals ~~and nondesignated public hospitals~~ for out-of-network and poststabilization services for the Low Income Health Program shall be determined under Section 14169.7.5.

~~SEC. 3.~~

*SEC. 8.* Section 14169.16 of the Welfare and Institutions Code is amended to read:

14169.16. (a) This article shall remain operative only until the later of the following:

(1) January 1, 2015.

(2) The date of the last payment of the quality assurance fee payments pursuant to Article 5.229 (commencing Section 14169.31).

(3) The date of the last payment from the department pursuant to this article.

(b) If this article becomes inoperative under paragraph (1) of subdivision (a), this article shall be repealed on January 1, 2015, unless a later enacted statute enacted before that date, deletes or extends that date.

(c) If this article becomes inoperative under paragraph (2) or (3) of subdivision (a), this article shall be repealed on January 1 of the year following the date this article becomes inoperative, unless a later enacted statute enacted before that date, deletes or extends that date.

~~SEC. 4.~~

*SEC. 9.* Section 14169.17 of the Welfare and Institutions Code is amended to read:

14169.17. Notwithstanding any other provision of law, if federal approval or a letter that indicates likely federal approval in accordance with Section 14169.34 has not been received on or before December 1, 2013, then this article shall become inoperative, and as of December 1, 2013, is repealed, unless a later enacted statute, that is enacted before December 1, 2013, deletes or extends that date.

~~SEC. 5.~~

*SEC. 10.* Section 14169.18 of the Welfare and Institutions Code is amended to read:

14169.18. If the director determines that this article has become inoperative pursuant to Section 14169.13, 14169.16, 14169.17, or 14169.40, the director shall execute a declaration stating that this determination has been made and stating the basis for this determination. The director shall retain the declaration and provide a copy, within five working days of the execution of the declaration, to the fiscal and appropriate policy committees of the Legislature. In addition, the director shall post the declaration on the department's Internet Web site and the director shall send the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

*SEC. 11. Section 14169.31 of the Welfare and Institutions Code is amended to read:*

14169.31. For the purposes of this article, the following definitions shall apply:

(a) (1) "Aggregate quality assurance fee" means, with respect to a hospital that is not a prepaid health plan hospital, the sum of all of the following:

(A) The annual fee-for-service days for an individual hospital multiplied by the fee-for-service per diem quality assurance fee rate.

(B) The annual managed care days for an individual hospital multiplied by the managed care per diem quality assurance fee rate.

(C) The annual Medi-Cal days for an individual hospital multiplied by the Medi-Cal per diem quality assurance fee rate.

(2) "Aggregate quality assurance fee" means, with respect to a hospital that is a prepaid health plan hospital, the sum of all of the following:

(A) The annual fee-for-service days for an individual hospital multiplied by the fee-for-service per diem quality assurance fee rate.

(B) The annual managed care days for an individual hospital multiplied by the prepaid health plan hospital managed care per diem quality assurance fee rate.

(C) The annual Medi-Cal managed care days for an individual hospital multiplied by the prepaid health plan hospital Medi-Cal managed care per diem quality assurance fee rate.

(D) The annual Medi-Cal fee-for-service days for an individual hospital multiplied by the Medi-Cal per diem quality assurance fee rate.

(3) "Aggregate quality assurance fee after the application of the fee percentage" means the aggregate quality assurance fee multiplied by the fee percentage for each subject fiscal year.

(b) "Annual fee-for-service days" means the number of fee-for-service days of each hospital subject to the quality assurance fee, as reported on the days data source.

(c) "Annual managed care days" means the number of managed care days of each hospital subject to the quality assurance fee, as reported on the days data source.

(d) "Annual Medi-Cal days" means the number of Medi-Cal days of each hospital subject to the quality assurance fee, as reported on the days data source.

(e) "Converted hospital" shall mean a hospital described in subdivision (b) of Section 14169.1.

(f) "Days data source" means the hospital's Annual Financial Disclosure Report filed with the Office of Statewide Health Planning and Development as of May 5, 2011, for its fiscal year ending during 2009.

(g) "Designated public hospital" shall have the meaning given in subdivision (d) of Section 14166.1 as of January 1, 2011.

(h) "Exempt facility" means any of the following:

(1) A public hospital, which shall include either of the following:

(A) A hospital, as defined in paragraph (25) of subdivision (a) of Section 14105.98.

(B) A tax-exempt nonprofit hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code and operating a hospital owned by a local health care district, and is affiliated with the health care district hospital owner by means of the district's status as the nonprofit corporation's sole corporate member.

(2) With the exception of a hospital that is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, a hospital that is a hospital designated as a specialty hospital in the hospital's

Office of Statewide Health Planning and Development Hospital Annual Financial Disclosure Report for the hospital's fiscal year ending in the 2009 calendar year.

(3) A hospital that satisfies the Medicare criteria to be a long-term care hospital.

(4) A small and rural hospital as specified in Section 124840 of the Health and Safety Code designated as that in the hospital's Office of Statewide Health Planning and Development Hospital Annual Financial Disclosure Report for the hospital's fiscal year ending in the 2009 calendar year.

(i) "Federal approval" means the last approval by the federal government required for the implementation of this article and Article 5.228 (commencing with Section 14169.1).

(j) (1) "Fee-for-service per diem quality assurance fee rate" means a fixed daily fee on fee-for-service days.

(2) The fee-for-service per diem quality assurance fee rate shall be three hundred ~~nine dollars and eighty-six cents ($309.86)~~ *eight dollars and thirty-six cents ($308.36)* per day.

(3) Upon federal approval or conditional federal approval described in Section 14169.34, the director shall determine the fee-for-service per diem quality assurance fee rate based on the funds required to make the payments specified in Article 5.228 (commencing with Section 14169.1), in consultation with the hospital community.

(k) "Fee-for-service days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric care," and "rehabilitation care," and the payer category is reported as "Medicare traditional," "county indigent programs-traditional," "other third parties-traditional," "other indigent," and "other payers," for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(*l*) "Fee percentage" means a fraction, expressed as a percentage, the numerator of which is the amount of payments for each subject fiscal year under Sections 14169.2, 14169.3, 14169.5, and 14169.7.5, for which federal financial participation is available and the denominator of which is four billion eight hundred ~~ninety-seven million eight hundred sixty-six thousand nine hundred thirty-seven dollars ($4,897,866,937)~~ *sixty-six million seven*

*hundred four thousand one hundred fifteen dollars ($4,866,704,115)*.

(m) "General acute care hospital" means any hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code.

(n) "Hospital community" means any hospital industry organization or system that represents hospitals.

(o) "Managed care days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric care," and "rehabilitation care," and the payer category is reported as "Medicare managed care," "county indigent programs-managed care," and "other third parties-managed care," for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(p) "Managed care per diem quality assurance fee rate" means a fixed fee on managed care days of eighty-six dollars and forty cents ($86.40) per day.

(q) "Medi-Cal days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric care," and "rehabilitation care," and the payer category is reported as "Medi-Cal traditional" and "Medi-Cal managed care," for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(r) "Medi-Cal fee-for-service days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric care," and "rehabilitation care," and the payer category is reported as "Medi-Cal traditional" for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(s) "Medi-Cal managed care days" means inpatient hospital days as reported on the days data source where the service type is reported as "acute care," "psychiatric care," and "rehabilitation care," and the payer category is reported as "Medi-Cal managed care" for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(t) "Medi-Cal per diem quality assurance fee rate" means a fixed fee on Medi-Cal days of three hundred eighty-three dollars and twenty cents ($383.20) per day.

(u) "New hospital" means a hospital operation, business, or facility functioning under current or prior ownership as a private hospital that does not have a days data source or a hospital that has a days data source in whole, or in part, from a previous operator where there is an outstanding monetary liability owed to the state in connection with the Medi-Cal program and the new operator did not assume liability for the outstanding monetary obligation.

(v) "Nondesignated public hospital" means either of the following:

(1) A public hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2009, and satisfies the definition in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(2) A tax-exempt nonprofit hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2009, is operating a hospital owned by a local health care district, and is affiliated with the health care district hospital owner by means of the district's status as the nonprofit corporation's sole corporate member.

(w) "Prepaid health plan hospital" means a hospital owned by a nonprofit public benefit corporation that shares a common board of directors with a nonprofit health care service plan.

(x) "Prepaid health plan hospital managed care per diem quality assurance fee rate" means a fixed fee on non-Medi-Cal managed care days for prepaid health plan hospitals of forty-eight dollars and thirty-eight cents ($48.38) per day.

(y) "Prepaid health plan hospital Medi-Cal managed care per diem quality assurance fee rate" means a fixed fee on Medi-Cal managed care days for prepaid health plan hospitals of two hundred fourteen dollars and fifty-nine cents ($214.59) per day.

(z) "Prior fiscal year data" means any data taken from sources that the department determines are the most accurate and reliable at the time the determination is made, or may be calculated from the most recent audited data using appropriate update factors. The data may be from prior fiscal years, current fiscal years, or projections of future fiscal years.

(aa) "Private hospital" means a hospital that meets all of the following conditions:

(1) Is licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code.

(2) Is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, or is not designated as a specialty hospital in the hospital's Office of Statewide Health Planning and Development Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2009.

(3) Does not satisfy the Medicare criteria to be classified as a long-term care hospital.

(4) Is a nonpublic hospital, nonpublic converted hospital, or converted hospital as those terms are defined in paragraphs (26) to (28), inclusive, respectively, of subdivision (a) of Section 14105.98.

(ab) "Program period" means the period from July 1, 2011, to December 31, 2013, inclusive.

(ac) "Subject fiscal quarter" means a state fiscal quarter during the program period.

(ad) "Subject fiscal year" means a state fiscal year that ends after July 1, 2011, and begins before January 1, 2014.

(ae) "Upper payment limit" means a federal upper payment limit on the amount of the Medicaid payment for which federal financial participation is available for a class of service and a class of health care providers, as specified in Part 447 of Title 42 of the Code of Federal Regulations. The applicable upper payment limit shall be separately calculated for inpatient and outpatient hospital services.

*SEC. 12. Section 14169.33 of the Welfare and Institutions Code is amended to read:*

14169.33. (a) (1) All fees required to be paid to the state pursuant to this article shall be paid in the form of remittances payable to the department.

(2) The department shall directly transmit the fee payments to the Treasurer to be deposited in the Hospital Quality Assurance Revenue Fund, created pursuant to Section 14167.35. Notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on deposits in the fund from the

proceeds of the fee assessed pursuant to this article shall be retained in the fund for purposes specified in subdivision (b).

(b) Notwithstanding subdivision (c) of Section 14167.35 and subdivision (b) of Section 14168.33, all funds from the proceeds of the fee assessed pursuant to this article in the Hospital Quality Assurance Revenue Fund, together with any interest and dividends earned on money in the fund, shall, upon appropriation by the Legislature, continue to be used exclusively to enhance federal financial participation for hospital services under the Medi-Cal program, to provide additional reimbursement to, and to support quality improvement efforts of, hospitals, and to minimize uncompensated care provided by hospitals to uninsured patients, as well as to pay for the state's administrative costs and to provide funding for children's health coverage, in the following order of priority:

(1) To pay for the department's staffing and administrative costs directly attributable to implementing Article 5.228 (commencing with Section 14169.1) and this article, not to exceed two million five hundred thousand dollars ($2,500,000) for the program period.

(2) To pay for the health care coverage for children in the amount of eighty-five million dollars ($85,000,000) for each subject fiscal quarter during the 2011–12 subject fiscal year, and in the amount of ninety-six million seven hundred fifty thousand dollars ($96,750,000) for each subject fiscal quarter during the 2012–13 and 2013–14 subject fiscal years.

(3) To make increased capitation payments to managed health care plans pursuant to Article 5.228 (commencing with Section 14169.1).

(4) To reimburse the General Fund for the increase in the overall compensation to a private hospital that is attributable to its change in status from contract hospital to noncontract hospital, pursuant to subdivision (a) of Section 14169.10.

(5) To make increased payments or grants to hospitals pursuant to Article 5.228 (commencing with Section 14169.1).

(6) To make increased payments to mental health plans pursuant to Article 5.228 (commencing with Section 14169.1).

(7) To make supplemental payments for out-of-network emergency and poststabilization services provided by private hospitals ~~and nondesignated public hospitals to Medi-Cal expansion~~ *to Medicaid Coverage Expansion* enrollees in the Low Income

Health Program in the amount of ~~thirty-seven million five hundred thousand dollars ($37,500,000)~~ *thirty-three million two hundred thousand dollars ($33,200,000)* for each fiscal quarter pursuant to Section 14169.7.5.

(c) Any amounts of the quality assurance fee collected in excess of the funds required to implement subdivision (b), including any funds recovered under subdivision (d) of Section 14169.13 or subdivision (e) of Section 14169.38, shall be refunded to general acute care hospitals, pro rata with the amount of quality assurance fee paid by the hospital, subject to the limitations of federal law. If federal rules prohibit the refund described in this subdivision, the excess funds shall be deposited in the Distressed Hospital Fund to be used for the purposes described in Section 14166.23, and shall be supplemental to and not supplant existing funds.

(d) Any methodology or other provision specified in Article 5.228 (commencing with Section 14169.1) or this article may be modified by the department, in consultation with the hospital community, to the extent necessary to meet the requirements of federal law or regulations to obtain federal approval or to enhance the probability that federal approval can be obtained, provided the modifications do not violate the spirit and intent of Article 5.228 (commencing with Section 14169.1) or this article and are not inconsistent with the conditions of implementation set forth in Section 14169.40.

(e) The department, in consultation with the hospital community, shall make adjustments, as necessary, to the amounts calculated pursuant to Section 14169.32 in order to ensure compliance with the federal requirements set forth in Section 433.68 of Title 42 of the Code of Federal Regulations or elsewhere in federal law.

(f) The department shall request approval from the federal Centers for Medicare and Medicaid Services for the implementation of this article. In making this request, the department shall seek specific approval from the federal Centers for Medicare and Medicaid Services to exempt providers identified in this article as exempt from the fees specified, including the submission, as may be necessary, of a request for waiver of the broad-based requirement, waiver of the uniform fee requirement, or both, pursuant to paragraphs (1) and (2) of subdivision (e) of Section 433.68 of Title 42 of the Code of Federal Regulations.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this article or Article 5.228 (commencing with Section 14169.1) by means of provider bulletins, all plan letters, or other similar instruction, without taking regulatory action. The department shall also provide notification to the Joint Legislative Budget Committee and to the appropriate policy and fiscal committees of the Legislature within five working days when the above-described action is taken in order to inform the Legislature that the action is being implemented.

~~SEC. 6.~~

*SEC. 13.* Section 14169.41 of the Welfare and Institutions Code is amended to read:

14169.41. (a) This article shall remain operative only until the later of the following:

(1) January 1, 2015.

(2) The date of the last payment of the quality assurance fee payments pursuant to this article.

(3) The date of the last payment from the department pursuant to Article 5.228 (commencing with Section 14169.1).

(b) If this article becomes inoperative under paragraph (1) of subdivision (a), this article shall be repealed on January 1, 2015, unless a later enacted statute enacted before that date, deletes or extends that date.

(c) If this article becomes inoperative under paragraph (2) or (3) of subdivision (a), this article shall be repealed on January 1 of the year following the date this article becomes inoperative, unless a later enacted statute enacted before that date, deletes or extends that date.

~~SEC. 7.~~

*SEC. 14.* Section 14169.42 of the Welfare and Institutions Code is amended to read:

14169.42. If the director determines that this article has become inoperative pursuant to Section 14169.37, 14169.38, 14169.40, or 14169.41, the director shall execute a declaration stating that this determination has been made and stating the basis for this determination. The director shall retain the declaration and provide a copy, within five working days of the execution of the declaration, to the fiscal and appropriate policy committees of the Legislature. In addition, the director shall post the declaration on

the department's Internet Web site and the director shall send the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

*SEC. 15. The sum of two hundred thousand dollars ($200,000) is hereby appropriated from the General Fund to the State Department of Health Care Services for administration.*

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